THE ORIENTAL INSURANCE COMPANY LIMITED
Regd. Office: Oriental House, A-25/27,
Asaf Ali Road, New Delhi-110002
CIN No.U66010DL1947GOI007158

SAKSHAM SWASTHYA POLICY-ORIENTAL PROSPECTUS

1. SALIENT FEATURES

Coverage Basis	Individual basis only
Category of Cover	Indemnity and Benefit
Sum insured	On Individual basis — SI shall apply to each individual member
Sum insured available(in INR)	4lacs and 5 lacs
Policy Period	1 Year
Eligibility	Policy can be availed on Individual basis. Age eligibility for adults: 18 years to 65 years Age eligibility for Children: Newborn to 17 years 40% or more disability as certified by the competent authority as per the Disability Act 2016. Persons with HIV/AIDS.
Grace Period	For Yearly mode of payment , a fixed period of 30 days is to be allowed as Grace. Period and for all other modes of payment a fixed period of 15 days be allowed as grace period.
Hospitalisation Expenses	Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. Time limit of 24 hrs shall not apply in respect of Day Care Treatment.
Pre-Hospitalisation	For 30 days prior to the date of hospitalization
Post Hospitalisation	For 60 days from the date of discharge from the hospital
Sublimit for Room/ Medical Practitioner`s fee	1. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to maximum of 1% of the sum per day. 2.1ntensive Care Unit (ICU) charges charges all-inclusive as provided by the Hospital / Nursing Home up to maximum of 2% of the sum insured per day.
Cataract Treatment	Up to Rs.40,000/-(including IOL), per each eye in one policy year
Modern Treatment	Covered for listed procedures up to 50% of sum insured available for Inpatient Hospitalisation Care
Ambulance service charges	Expenses covered up to Rs. 2000 per hospitalisation

AYUSH	Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines shall be covered up to 50% of sum insured, during each Policy year as specified in the policy.
Pre-Existing Disease	Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered after specific waiting periods.
Initial Waiting period	30 days for all claims except resulting from Accident and 90 days for lumpsum benefit under HIV/AIDS.
PED waiting period	48 months (For pre-existing diseases other than the pre-existing Disability and HIV/AIDS covered)
Specific Disease/ illness waiting period	As defined in the policy.
Waiting Period and specific Sublimit for HIV AIDS Cover	For HIV/AIDS cover: a. Initial waiting period of 30 days will be applicable for Indemnity basis cover and 90 days shall be applicable for Benefit basis cover b. Sum Insured would be available for Hospitalisation Expenses as per terms and conditions of the policy. c.In case the CD4 count of insured is/goes below 150, then we will pay Rs.50,000/- as lumpsum amount to the insured. d. The claim under point (c) mentioned above shall be payable once in the lifetime of the Insured Person and shall not be necessarily linked to an Inpatient Hospitalisation claim made under the policy.
Waiting Period and specific Sublimit for Disability Cover	For Disability Cover: 24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.
Co-pay	20% on all claims made under the policy unless waiver for Co-pay is opted and premium is paid for the same

2. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and other gender and references to any statutory enactment includes subsequent changes to the same.

2.1 Standard Definitions

1. **Accident** means sudden, unforeseen, and involuntary event caused by external, visible, and violent means.

2. **Ambulance Services** means ambulance service charges reasonably and necessarily incurred in shifting the Insured Person from residence to Hospital for admission in emergency ward / ICU or from one Hospital / Nursing Home to another Hospital / Nursing Home, by registered ambulance only. The ambulance service charges are payable only if the Hospitalization expenses are admissible under the Policy.

3. **Any one Illness** means continuous period of illness and includes relapse within 45 days from the

date of last consultation with the Hospital / Nursing Home where treatment was taken.

4. **AYUSH Treatment** refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

5. **AYUSH Hospital** means an AYUSH Hospital is a healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   i. Central or State Government AYUSH Hospital; or
   ii. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/ Central Council for Homeopathy; or
   iii. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      a) Having at least 5 in-patient beds.
      b) Having qualified AYUSH Medical Practitioner in charge round the clock;
      c) Having dedicated AYUSH therapy sections as required and / or has equipped operation theatre where surgical procedures are to be carried out;
      d) Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

6. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical / para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner in charge round the clock;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
7. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

8. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization is approved.

9. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

10. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure, or position.
    i. Internal Congenital Anomaly– Congenital Anomaly which is not in the visible and accessible

parts of the body.

ii. External Congenital Anomaly– Congenital Anomaly which is in the visible and accessible parts of the body

11. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.

12. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rate able proportion of Sum Insured. If two or more policies are taken by the insured during a period from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

    -is fixed in nature;

    -does not have any relation to the treatment costs;

13. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under:
    i. has qualified nursing staff under its employment.
    ii. has qualified medical practitioner/s in charge.
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

14. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

A. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. because Of technological advancement, and

B. Which would have otherwise required hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list.

NOTE :Treatment normally taken on an out-patient basis is not included in the scope of this definition.

15. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions, and surgery.

16. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

17. **Emergency Care** means management for an Illness which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.

18. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existing diseases. Coverage is not available for the period for which no premium is received.

19. **Hospital/Nursing Home** A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:

A. has qualified nursing staff under its employment round the clock;
B. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
C. has qualified medical practitioner(s) in charge round the clock;
D. has a fully equipped operation theatre of its own where surgical procedures are carried out;
E. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

*Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

- The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
- The Bombay Nursing Homes Registration Act, 1949
- The Delhi Nursing Home Registration Act, 1953
- The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (RagistrikaranTathaAnugyapan) Adhiniyam, 1973.
- The Manipur Homes and Clinics Registration Act, 1992
- The Nagaland Health Care Establishments Act, 1997
- The Orissa Clinical Establishments (Control and Regulations) Act, 1990
- The Punjab State Nursing Home Registration Act, 1991
- The West Bengal Clinical Establishment Act, 1950

20. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

21. **I .D. CARD** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

22. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible, and evident means which is verified and certified by a Medical Practitioner.

23. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    i. Acute condition - Acute condition is a disease, Illness that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness which leads to full recovery

ii. Chronic condition - A chronic condition is defined as a disease, Illness that has one or more of the following characteristics:
    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
    b. it needs ongoing or long-term control or relief of symptoms
    c. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it
    d. it continues indefinitely.
    e. it recurs or is likely to recur.

24. **In-patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

25. **Insured Person** means person(s) named in the schedule of the Policy.

26. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

27. **ICU Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

28. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription.

29. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

30. **Medical Necessary Treatment** means any treatment, tests, medication, or stay in Hospital or part of stay in Hospital which:
    i. is required for the medical management of the illness or injury suffered by the Insured Person.
    ii. must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity.
    iii. must have been prescribed by a medical practitioner.
    iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

31. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within

its jurisdiction; and is acting within the scope and jurisdiction of license.

32. **Migration** means the right accorded to health insurance policyholders (including all members under Family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

33. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

34. **New born Baby** means baby born during the Policy Period and is aged up to 90 days.

35. **Non-Network Provider** means any Hospital, Day Care Centre or other provider that is not part of the Network.

36. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

37. **OPD Treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

38. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

39. **Pre-Existing Disease (PED)**: Pre-existing disease means any condition, ailment, injury, or disease.
    i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or
    ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.

40. **Post-Hospitalization Medical Expenses** means medical expenses incurred for a period up to 60 days from the date of discharge from the Hospital, provided that:
    A. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    B. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

41. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

42. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India.

43. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for Pre-Existing Diseases, time-bound exclusions and for all waiting periods.

44. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

45. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

46. **Surgery or Surgical Procedures** means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.

47. **Third Party Administrator (TPA)** means any person who is licensed under the IRDAI (Third Party Administrators – Health Service) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services

48. **Unproven/Experimental Treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

2.2 Specific Definitions

1. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his profession whether he/she is trained or not.

2. **Age** means completed years on last birthday as on Commencement Date.

3. **Antiretroviral therapy (ART)** is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs.

4. **Associated Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner. In case of copayment associated with room rent higher than the entitled room rent limit, Associated Medical Expenses will not include:
   a. Cost of pharmacy and consumables.
   b. Cost of implants and medical devices
   c. Cost of diagnostics

5. **Alternative/AYUSH Treatment** refers to hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6. **Biological Attack** or **Weapons** means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

7. **Chemical attack** or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, in capacitating disablement or death.

8. **Company/We/Our/Us/** means THE ORIENTAL INSURANCE COMPANY LIMITED.

9. **CD4** cells are a type of white blood cells, also called as CD4 T lymphocytes or 'helper T cells' which serve as primary receptor for HIV.

10. **Diagnostic Centre** means a place where diagnostic tests and exploratory or therapeutic procedures required for the detection, identification and treatment of a medical condition are done.

11. **Person with Disability/Disability/Disabled** means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.

12. **HIV** means Human Immunodeficiency Virus

13. **Life-threatening emergency** shall mean a serious medical condition or symptom, which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long-term impairment of the Insured Person's health, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

14. **Mental Illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

15. **Mental Health Professional**

    A. a psychiatrist or

    B. a professional registered with the concerned State Authority under section 55; or

    C. a professional having a post-graduate degree (Ayurveda) in Mano VigyanAvum Manas Roga or a post- graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post- graduate degree (Siddha) in SirappuMaruthuvam;

16. **Mental Health Establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person, where persons with

mental Illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general Hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organization or any other entity or person; but does not include a family residential place where a person with mental Illness resides with his relatives or friends;

17. **Policy Period** means the period of coverage as mentioned in the schedule.

18. **Policy Schedule** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

19. **Sum Insured** means the pre-defined limit specified in the Policy Schedule and represents the maximum, total and cumulative liability for any and all claims made under the Policyin respect of each insured person as mentioned in the Policy Schedule.

20. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the Waiting Period, diseases/ treatments shall be covered provided the Policy has been continuously renewed without any break.

21. **Family** consists of the Insured and/ or anyone or more of the family members as mentioned below:
    - Legally wedded spouse.
    - Dependent Children (i.e. natural or legally adopted) up to the age of 17 years.
    - Parents and/or Parents-in-law.
    - Dependent siblings

3. COVERAGE

HOSPITALIZATION COVER

3.1 Inpatient Care:

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy Year, up to the Sum insured as specified in the Policy Schedule (other than any sub-limits, co-pay as specified in the policy), for:

i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to maximum of 1% of the Sum Insured per day.
ii. Intensive Care Unit (ICU) expenses up maximum of to 2% of Sum Insured per day.
iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees
iv. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines &Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and similar expenses.

a. Number of days of stay under 'i' & 'ii' above should not exceed total number of days of admission in the Hospital. All related expenses (including iii & iv above) shall also be payable as per the entitled room category based on the Room Rent limit as mentioned above. This will not apply on pharmaceuticals, consumables, diagnostics, medical devises and body implants.

b. Any expenses in excess of reasonable and customary charges as defined under 2.1(44), or, in excess of the negotiated prices (in case of network hospitals) shall not be borne by the insurer

Other expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment necessitated due to disease or injury (for inpatient care only).
iii. Plastic surgery necessitated due to disease or injury.
iv. All day care treatments as per ANNEXURE-III of policy(Any other day care treatment as mentioned in clause 2.1(14) and for which prior approval from Company / TPA is obtained in writing.

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment.
2. The above-mentioned Medical Expenses shall be payable only after the first commencement of the Policy with the Company.

3.2AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to 50% of sum insured as specified in the policy in any AYUSH Hospital.

3.3 Pre-Hospitalization Medical Expenses:

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 3.1 (Inpatient Care) or Section 3.2(AYUSH Treatment) or Section 3.7 (Modern Treatments) in respect of that Insured Person.
ii. Pre-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

3.4 Post-Hospitalization Medical Expenses:

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, following an admissible hospitalization covered under the Policy during the policy period.

Conditions:

i. The claim is accepted under Section 3.1 (Inpatient Care) or Section 3.2(AYUSH Treatment) or Section 3.7 (Modern Treatments) in respect of that Insured Person.
ii. Post-hospitalization Medical Expenses can be claimed under this Section on a Reimbursement basis only.

3.5 Ambulance service charges

The Company will reimburse Charges for expenses incurred towards ambulance charges for transportation of an Insured person, subject to a maximum of Rs.2000/- per hospitalisation.

Specific Conditions:

The Company will reimburse payments under this Benefit provided that.

i. The medical condition of the Insured Person requires immediate ambulance services from the place where the Insured Person is Injured or is suffering from an Illness to a Hospital where appropriate medical treatment can be obtained or from the existing Hospital to another Hospital as advised by the treating Medical Practitioner in writing for management of the current Hospitalization.
ii. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation.
iii. The ambulance service is offered by a healthcare or Registered Ambulance Service Provider.
iv. The original Ambulance bills and payment receipt is submitted to the Company.
v. The Company has accepted a claim under Section 3.1 (Inpatient Care) above in respect of the same period of Hospitalization or Section 3.2(AYUSH Treatment) or Section 3.7 (Modern Treatments).
vi. Any payment under this Benefit will be excluded if the Insured Person is transferred to any Hospital or diagnostic center for evaluation purposes only.

3.6 Cataract Treatment

The company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of Rs.40, 000/-, per each eye (including IOL) in one policy year.

3.7Modern Treatment:

The following procedures will be covered (wherever medically indicated) either as In patient or as part of Day Care Treatment in a Hospital up to 50% of Sum Insured, specified in the Policy, during the Policy Period.

a. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
b. Balloon Sinuplasty
c. Deep Brain stimulation
d. Oral chemotherapy
e. Immunotherapy- Monoclonal Antibody to be given as injection.
f. Intra Vitreal injections
g. Robotic surgeries
h. Stereotactic radio Surgeries
i. Bronchial Thermoplasty
j. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
k. IONM- (lntra Operative Neuro Monitoring)
l. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

4. EXCLUSIONS

The Company is not liable to make any payment under the Policy in connection with or in respect of the following expenses till the expiry of the waiting period and any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or any way attributable to any of the following unless expressly stated to the contrary in this Policy.

4.1 Standard Exclusions

1. **Pre-Existing Diseases (Code- Excl01)**

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24months for pre-existing disability/ 48 months for all pre-existing conditions other than HIV/AIDS and Disability(as mentioned in Policy) of continuous coverage

after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of number of months (as mentioned in Policy) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Us.

2. First 30 days waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy Commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3. Specified disease/procedure waiting period- Code- Excl02

a) Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of specific waiting period of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

	Ailment / Disease / Surgery	**Waiting Period**
I	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	1 year
Ii	Polycystic ovarian diseases.	1 year
Iii	Surgery of hernia.	2 years
Iv	Surgery of hydrocele.	2 years
V	Non infective Arthritis.	2 years
Vi	Undescendent Testes.	2 Years
Vii	Cataract.	2 Years
Viii	Surgery of benign prostatic hypertrophy.	2 Years

Ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	2 Years
X	Fissure / Fistula in anus.	2 Years
Xi	Piles.	2 Years
Xii	Sinusitis and related disorders.	2 Years
Xiii	Surgery of gallbladder and bile duct excluding malignancy.	2 Years
Xiv	Surgery ofgenito-urinary system excluding malignancy.	2 Years
Xv	Pilonidal Sinus.	2 Years
Xvi	Gout and Rheumatism.	2 Years
Xvii	Hypertension.	90 days
Xviii	Diabetes.	90 days
Xix	Calculus diseases.	2 Years
Xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	2 Years
Xxi	Surgery of varicose veins and varicose ulcers.	2 Years
Xxii	Joint Replacement due to Degenerative condition.	4 Years
Xxiii	Age related osteoarthritis and Osteoporosis.	4 Years

4. **Investigation & Evaluation- Code- Excl04**
   a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
   b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
5. **Rest Cure, rehabilitation, and respite care- Code- Excl05**
   a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. **Obesity/ Weight Control: Code- Excl06**
   Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   1) Surgery to be conducted is upon the advice of the Doctor.
   2) The surgery/Procedure conducted should be supported by clinical protocols.
   3) The member must be 18 years of age or older and
   4) Body Mass Index (BMI).
      a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. coronary heart disease

iii. Severe Sleep Apnoea

iv. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

9. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

10. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

11. Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations **or** following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl12**

13. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

15. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eyesight due to refractive error less than 7.5 dioptres.

16. **Unproven Treatments**: **Code- Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility: Code- Excl17**
Expenses related to sterility and infertility. This includes:
(i) Any type of contraception, sterilization
(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
(iii) Gestational Surrogacy
(iv) Reversal of sterilization

18. **Maternity: Code Excl18**
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy.
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

4.2 Specific Exclusions

1. **Hormone Replacement Therapy** Expenses for hormone replacement therapy, unless part of Medically Necessary Treatment, except for Puberty and Menopause related Disorders
2. **General Debility, Congenital External Anomaly** General debility, congenital external anomaly.
3. **Self Inflicted Injury** Treatment for intentional self-inflicted injury, attempted suicide.
4. **Stem Cell Surgery** Stem Cell Surgery (except Hematopoietic stem cells for bone marrow transplant for hematological conditions).
5. **Circumcision** unless necessary for treatment of a disease (if not excluded otherwise) or necessitated due to an accident.
6. **Vaccination or Inoculation.** Vaccination or inoculation unless forming part of treatment and requires Hospitalization, except as and to the extent provided for under Section 3.1 (Anti Rabies Vaccination).
7. **Massages, Steam Bath, Alternative Treatment (Other than Ayurveda and Homeopathy)** Massages, steam bath, expenses for alternative or AYUSH treatments (other than Ayurveda and Homeopathy), acupuncture, acupressure, magneto-therapy and similar treatment.
8. **Dental treatment** Dental treatment, unless necessitated due to an Injury.
9. **Out Patient Department (OPD)** Any expenses incurred on OPD.
10. **Stay in Hospital which is not Medically Necessary.** Stay in hospital which is not medically necessary.
11. **Spectacles, Contact Lens, Hearing Aid, Cochlear Implants** Spectacles, contact lens, hearing aid, cochlear implants.
12. **Non Prescription Drug** Drugs not supported by a prescription, private nursing charges, referral fee to family physician, outstation doctor/surgeon/consultants' fees and similar expenses (as listed in respective Annexure-II).
13. **Treatment not related to Disease for which Claim is Made** Treatment which the insured person

was on before Hospitalization for the Illness/Injury, different from the one for which claim for Hospitalization has been made.

14. **Equipment's** External/durable medical/non-medical equipment's/instruments of any kind used for diagnosis/ treatment including CPAP, CAPD, infusion pump, ambulatory devices such as walker, crutches, belts, collars, caps, splints, slings, braces, stockings, diabetic foot-wear, glucometer, thermometer and similar related items (as listed in respective Annexure-II) and any medical equipment which could be used at home subsequently.
15. **Items of personal comfort** Items of personal comfort and convenience (as listed in respective Annexure-II) including telephone, television, aya, barber, beauty services, baby food, cosmetics, napkins, toiletries, guest services.
16. **Service charge/ registration fee** Any kind of service charges including surcharges, admission fees, registration charges and similar charges (as listed in respective Annexure-II) levied by the hospital.
17. **Home visit charges** Home visit charges during Pre and Post Hospitalization of doctor, attendant and nurse.
18. **War** (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
19. **Radioactivity** Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

20. **Treatment taken outside the geographical limits of India.**
21. **Treatments** such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
22. **Venereal/ Sexually Transmitted disease** except HIV/AIDS.
23. **Stem cell storage.**
24. **Non-Payable items:** The expenses that are not covered in this Policy are placed under List-I of **Annexure-II** of policy.
25. **Permanently Excluded Diseases** In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on the insured's consent), policyholder is not entitled to get the coverage for specified ICD coded as listed below:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9

2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill- defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemiavera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis

9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 - Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

4.3 SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH DISABILITY

The Company will indemnify reasonable and customary charges for medical expenses incurred towards Inpatient Hospitalization arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons With Disabilities Act, 2016 subject to the terms and limits mentioned below.

i. Any treatment for the pre-existing disability covered, will have a waiting period of 24 months from the first policy inception date.
ii. Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy.

4.4 SPECIFIC CONDITION APPLICABLE FOR PERSONS WITH HIV-AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Condition

i. This cover will exclude cost for any Anti-Retroviral Treatment.
ii. Initial waiting period of 30 days will be applicable for Indemnity basis cover and 90 days shall be applicable for Benefit basis cover
iii. Sum Insured would be available for Hospitalisation Expenses as per terms and conditions of the policy.
iv. In case the CD4 count of insured is/goes below 150, then we will pay Rs.50, 000/- as lumpsum amount to the insured.
v. The claim under point (iv) mentioned above shall be payable once in the lifetime of the Insured Person and shall not be necessarily linked to an Inpatient Hospitalisation claim made under the policy.

5 GENERAL TERMS AND CONDITIONS

5.1 Standard terms & Conditions

1. Disclosure of Information

The Policy shall be void and all premiums paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description, or non-disclosure of any Material Fact by the Insured Person.

2. Condition Precedent to Admission of Liability

The Due observance and fulfillment of the terms and conditions of the Policy, by the Insured Person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

3. Claim Settlement (provision for Penal interest)

- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- However, where the circumstance of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment of claim. ("Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

4. Complete Discharge

Any payment to the Insured Person or his/her nominees or his/her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Multiple Policies

i. In case of multiple policies taken by an Insured person during a period from the same or one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy
ii. Insured person having multiple policies shall also have the right to prefer claims under this policy

for the amounts disallowed under any other policy / policies/ even if the Sum Insured is not exhausted. Then the Insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the Sum Insured under a single policy, the Insured Beneficiary shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

v. Under this product, no insured can take more than one policy from any or all insurers.

vi. In case of this product, if the Insured takes more than one policy from any or all Insurers the current policy (this policy) stands lapsed.

6. Fraud

If any claim made by the Insured Person, is any respect of fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the Insurer or to induce the Insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured person does not believe to be true;

b) the active concealment of a fact by the Insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Cancellation

The Insured may cancel this Policy by giving 15days' written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Refund %	
Refund of Premium (basis Policy Period)	
Timing of Cancellation	
Up to to 30 days	75.00%
31 to 90 days	50.00%
91 days to 180 days	25.00%

181 days to 365 days	0.00%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by You under this Policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the Company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link:-
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

9. Portability

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.

ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link -
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

10. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

11. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalments basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period of 15 days would be given to pay the installment premium due for the Policy.
ii. During such grace period, Coverage will not be available from the installment premium payment due date till the date of receipt of premium by Company.
iii. The Benefits provided under — "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will get cancelled.
vi. In case of a claim, annual premium to be deposited by the Insured before payment of claim.

12. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

13. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three (3) months before the changes are affected.

14. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals of the Policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

lf the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

15. **Redressal of Grievance** In case of any grievance the insured person may contact the company through

Website: www.orientalinsurance.org.in
Toll free: 1800118485 Or 011- 33208485
E-mail: csd@orientalinsurance.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.If insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at: Customer Service Department Oriental House, Asaf Ali Road,New Delhi-110002. For updated details of grievance officer, kindly refer the link
https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7-5cac- c613-ffc05d578a3e
Insurance Ombudsman —The insured person many also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-I

16. Nomination

The policy holder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policy holder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the policy is made. ln the event of death of the Insured Person, the Company will pay the nominee (as named in the Policy Schedule/endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

5.2 Specific Conditions

I. Condition Precedent to the contract

a. Change of Sum Insured

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

b. Material Change

The Insured Person shall notify the Company in writing of any material change in the risk in relation to the declaration made in the Proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

c. Notice and Communication

i. Any notice, direction, instruction, or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule/certificate of insurance.

d. Records to be maintained.

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

e. Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

II. Conditions applicable during the contract

a. Alterations in the Policy
The Proposal Form, Policy Schedule, Policy, Prospectus constitute the complete contract of insurance. This Policy constitutes the complete contract of insurance between the Policyholder and the Company. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed, and stamped by Company. All endorsement requests will be made by the Insured Person only. This Policy cannot be changed by anyone (including an insurance agent or broker) except the Company.

b. Revision and Modification of the Policy Product-
i. Any revision or modification will be done with the approval of the Authority. We shall notify You about revision /modification in the Policy including premium payable

thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect.

ii. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

c. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule be deemed to form part of the Policy and shall be read together as one document.

6 CLAIM PROCEDURE

6.1 Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA,

ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.

iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification.

iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.

v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details,

vi. ln case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

6.2 Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to Company within the prescribed time limit as specified hereunder.

S. No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

6.3 Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person’s discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

6.4 Documents to be submitted

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form.
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission.
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details. vii.Investigation / Diagnostic test reports etc. supported by the prescription from attending medical practitioner
vii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
viii. Sticker/invoices of the Implants, wherever applicable.
ix. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.
x. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
xi. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
xii. Legal heir/succession certificate, wherever applicable
xiii. Any other relevant document required by Company/TPA for assessment of the claim.

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.

2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

4. In case of lump sum payment for HIV/AIDS, Insured will need to submit the below mentioned documents for the processing of Claim:

   a. Identity proof of the claimant
   b. Dully filled Claim form
   c. Copy of Medical reports/records
   d. Copy of Diagnostic reports
   e. Medical Practitioner’s certificate
   f. Any other relevant document as requested by the Insurer.

On receipt of claim documents from Insured, Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment of benefit as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

6.5 Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 20% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

This co-payment can be waived off by paying an additional premium (optional).

6.6 Services Offered by TPA

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of preauthorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include:

i. Claim settlement and claim rejection.
ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

6.7 Payment of Claim

All claims under the Policy shall be payable in Indian currency only.

6.8 TPA Discount – 5.5% if TPA services are not opted for.

6.9 IRDAI REGULATION: This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017andIRDAI (Health Insurance) Regulations2016and Guidelines on Standardization in health insurance, IRDA Master Circular 2020 as amended from time to time.

6.10 JURISDICTION: All disputes or differences under or in relation to the Policy shall be determined by the Indian Courts and in accordance with the Indian Laws.

6.11 HOW TO APPLY FOR INSURANCE: The Proposer has to complete the Proposal Form and Enrolment Form in duplicate and submit Insured Person's details of each member. The proposer has to affix colored stamp size photographs of each of the members to be insured on the Enrolment Form against the name of the person. These photographs will be utilized by Third Party Administrator for preparing ID card for each of the members insured.

The Prospectus contains salient features of the Policy. For details, reference is to be made to the Policy. In case of any difference between the Prospectus and the Policy, the terms and conditions of the Policy shall prevail. The Prospectus and Proposal Form are part of the Policy. Hence please read the Prospectus carefully and sign the same. The Proposal Form is to be completed in all respects for each insured Person. Both the Prospectus and the Proposal Form are to be submitted to the office or to the agent.

Name: Signature

Address:

Place: Date:

Note: For legal interpretation only English version will be valid.

INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE

Section 41 of the Insurance Act 1938 provides as follows:

i. No person shall allow, or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate except such rebate as may be allowed in accordance with the published Prospectus or tables of the Insurer.
ii. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to Ten Lakh Rupees.

PREMIUM CHART:-

Premium per Insured (INR) (With Waiver of Co-payment) (Yearly)(Excluding GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	41,488	48,196	56,492	67,143	76,795	80,320
500,000	45,462	52,850	61,984	73,703	84,338	88,254

Premium per Insured (INR) (With Waiver of Co-payment) (Yearly)(Including GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	48,956	56,871	66,661	79,229	90,618	94,778
500,000	53,645	62,363	73,141	86,970	99,519	104,140

Premium per Insured (INR) (With Waiver of Co-payment) (Half-Yearly)(Excluding GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	21,574	25,062	29,376	34,914	39,934	41,766
500,000	23,640	27,482	32,232	38,325	43,856	45,892

Premium per Insured (INR) (With Waiver of Co-payment) (Half-Yearly)(Including GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	25,457	29,573	34,664	41,199	47,122	49,284
500,000	27,895	32,429	38,034	45,224	51,750	54,153

Premium per Insured (INR) (With Waiver of Co-payment) (Quarterly)(Excluding GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	10,994	12,772	14,970	17,793	20,351	21,285
500,000	12,047	14,005	16,426	19,531	22,350	23,387

Premium per Insured (INR) (With Waiver of Co-payment) (Quarterly)(Including GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	12,973	15,071	17,665	20,996	24,014	25,116
500,000	14,215	16,526	19,383	23,047	26,373	27,597

Premium per Insured (INR) (With Waiver of Co-payment) (Monthly)(Excluding GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	3,699	4,297	5,037	5,987	6,848	7,162
500,000	4,054	4,712	5,527	6,572	7,520	7,869

Premium per Insured (INR) (With Waiver of Co-payment) (Monthly)(Including GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	4,365	5,070	5,944	7,065	8,081	8,451
500,000	4,784	5,560	6,522	7,755	8,874	9,285

Premium per Insured (INR) (With Co-payment) (Yearly)(Excluding GST)

SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	33,190	38,557	45,194	53,714	61,436	64,256
500,000	36,369	42,280	49,588	58,962	67,471	70,603

Premium per Insured (INR) (With Co-payment) (Yearly)(Including GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	39,164	45,497	53,329	63,383	72,494	75,822
500,000	42,915	49,890	58,514	69,575	79,616	83,312

Premium per Insured (INR) (With Co-payment) (Half-Yearly)(Excluding GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	17,259	20,049	23,501	27,931	31,947	33,413
500,000	18,912	21,986	25,786	30,660	35,085	36,714

Premium per Insured (INR) (With Co-payment) (Half-Yearly)(Including GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	20,366	23,658	27,731	32,959	37,697	39,427
500,000	22,316	25,943	30,427	36,179	41,400	43,323

Premium per Insured (INR) (With Co-payment) (Quarterly)(Excluding GST)						
SI	**Age less than equal to 20 yrs**	**Age is 21-35 yrs**	**Age is 36-45 yrs**	**Age is 46-55 yrs**	**Age is 56-60 yrs**	**Age is >60 yrs**
400,000	8,795	10,218	11,976	14,234	16,281	17,028
500,000	9,638	11,204	13,141	15,625	17,880	18,710

Premium per Insured (INR) (With Co-payment) (Quarterly)(Including GST)

SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	10,378	12,057	14,132	16,796	19,212	20,093
500,000	11,373	13,221	15,506	18,438	21,098	22,078

Premium per Insured (INR) (With Co-payment) (Monthly)(Excluding GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	2,959	3,438	4,030	4,790	5,478	5,729
500,000	3,243	3,770	4,422	5,257	6,016	6,295

Premium per Insured (INR) (With Co-payment) (Monthly)(Including GST)						
SI	Age less than equal to 20 yrs	Age is 21-35 yrs	Age is 36-45 yrs	Age is 46-55 yrs	Age is 56-60 yrs	Age is >60 yrs
400,000	3,492	4,057	4,755	5,652	6,464	6,760
500,000	3,827	4,449	5,218	6,203	7,099	7,428

Loadings based on different disability conditions:

Disabilities/Disease	Loading applicable on the office premium rate
Thalassemia	200%
Sickle Cell Anaemia	200%
Muscular dystrophy	100%
cerebral palsy	100%
HIV/AIDS	100%
haemophilia	200%
chronic neurological disorders	75%

Illustration:

For an individual opting for SI cover of INR 5 Lacs, the following table demonstrates calculation of Premium:

Disability	Age	SI	Premium (With Waiver of Co-payment)	Applicable Loading	Premium Payable (after loading)
Sickle Cell Anaemia	37	500,000	61,984	200%	1,85,953

(In INR)

Note:-

- There is no loading or discount applicable for the rest of the disabilities covered under the proposed product.
- In case Insured is minor, proposer can be only as per the family definition under the policy but the premium shall be calculated only on the Insured (Minor) details.
- **TPA Discount** – 5.5% if TPA services are not opted for.

These Office Premium rates are applicable for insured's taking cover on individual basis.